



Weekly Client Care Notes

Flowsheets Used

- Urinary I and O
- Bowel Blood sugar
- Vital signs Weight
- Turn and reposition

Use nearest quarter hour in decimal form: 15 min = 0.25; 30 min = 0.5; 45 min = 0.75	Client Name (print):	Employee Name (print):
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Date (m/d/yy)	Day	Time In (hh:mm)	Time Out (hh:mm)	Total Hrs. (hh.mm)	Client Signature (Client must sign daily)	Employee Signature (Employee must sign daily)
	Sun					
	Mon					
	Tue					
	Wed					
	Thu					
	Fri					
	Sat					

Total Hours:		Employee Signature:
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To the Employee: Execution of this time sheet is your responsibility. You WILL NOT be paid if signatures or other info are incomplete.

I hereby certify that the information on this time sheet is true.

Procedure: Record the date and exact times of arrival and departure (above). Review the Client Care Plan and check the appropriate shaded areas (below) to indicate care ordered. Include the day of the month beneath each day header and specify level of care given and completion in columns below according to the following key: T=Total; A=Assist; S=Self; D=Decline.

	Care Plan	Su	M	Tu	W	Th	F	Sa	Care Plan	Su	M	Tu	W	Th	F	Sa
		Personal Hygiene								Activity						
Oral hygiene	<input type="checkbox"/>								Turn/position freq.	<input type="checkbox"/>						
Denture care	<input type="checkbox"/>								Transfer	<input type="checkbox"/>						
Complete bed bath	<input type="checkbox"/>								Range of motion	<input type="checkbox"/>						
Partial sponge	<input type="checkbox"/>								Assistive device	<input type="checkbox"/>						
Shower or tub	<input type="checkbox"/>								Ambulation	<input type="checkbox"/>						
Hair: shampoo/comb	<input type="checkbox"/>								Home Exercise (HEP)	<input type="checkbox"/>						
Nail care	<input type="checkbox"/>								Home Support, Nutrition, etc.							
Skin care	<input type="checkbox"/>								Prepare meals	<input type="checkbox"/>						
Ted/Jobst hose	<input type="checkbox"/>								Feeding	<input type="checkbox"/>						
Skin assessment	<input type="checkbox"/>								Feeding tube	<input type="checkbox"/>						
Shave: razor /elec.	<input type="checkbox"/>								Clean kitchen	<input type="checkbox"/>						
Foot care	<input type="checkbox"/>								Clean bathroom	<input type="checkbox"/>						
Dressing	<input type="checkbox"/>								Clean client area	<input type="checkbox"/>						
Elimination									Make/change bed	<input type="checkbox"/>						
Incontinence care	<input type="checkbox"/>								Laundry	<input type="checkbox"/>						
Use of briefs	<input type="checkbox"/>								Grocery shopping	<input type="checkbox"/>						
Indwelling catheter care	<input type="checkbox"/>								Errands	<input type="checkbox"/>						
Bedside commode	<input type="checkbox"/>								Intake/output	<input type="checkbox"/>						
Bedpan	<input type="checkbox"/>								Safety/fall risk	<input type="checkbox"/>						
Toilet	<input type="checkbox"/>								Neb. treatments	<input type="checkbox"/>						
Ostomy care	<input type="checkbox"/>								Med reminder	<input type="checkbox"/>						
Intermit. catheterization	<input type="checkbox"/>								Blood sugar remin.	<input type="checkbox"/>						
Bowel program	<input type="checkbox"/>								Vital signs	<input type="checkbox"/>						
	<input type="checkbox"/>								Weight	<input type="checkbox"/>						

Other info:

Change in Client Status:	Skin <input type="checkbox"/>	Mental status <input type="checkbox"/>	General strength <input type="checkbox"/>	ER visit <input type="checkbox"/>	Employee Signature:
RN supervisor/office notified?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date (m/d/yy):		Time (hh:mm):